

Conceptualization of Gender Nonconformity among Mental Health Professionals

Thesis

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Abstract

Individuals who are gender nonconforming often experience discrimination, violence, and limited social support. American culture conceptualizes gender in such a way that it makes it almost impossible for gender nonconforming individuals to express themselves freely without running into problems from the outside environment. Social support is imperative to individuals' ability to be resilient in their environments, and mental health professionals often help individuals achieve higher levels of social support. Hence, it is imperative for mental health professionals to understand the experiences of gender nonconforming individuals in such a way that ensures they will not possess transphobic beliefs, stereotypes, and biases. With limited research available to guide practice, this exploratory study sought to further explore ways in which mental health professionals from different disciplines conceptualize gender nonconformity and how this conceptualization is related to transphobia utilizing queer theory as a theoretical framework. A total of 64 mental health professionals working at 14 different mental health agencies responded to a survey questionnaire asking about gender nonconforming knowledge and beliefs. This research produced a greater understanding of how mental health professionals conceptualize gender nonconformity and identified potential needs for further research and education in this area.

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Curriculum Vitae

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Fields Of Study

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Introduction

Individuals that are gender nonconforming often experience discrimination, violence, and limited social support. Our culture conceptualizes gender in such a way that it makes it almost impossible for gender nonconforming individuals to express themselves freely without running into problems from the outside environment. Social support is imperative to individuals' ability to be resilient in their environments, and mental health professionals often help individuals achieve higher levels of social support. Hence, it is imperative for mental health professionals to understand the experiences of gender nonconforming individuals in such a way that ensures they will not possess and perpetuate transphobic beliefs, stereotypes, and biases. Our culture cultivates beliefs about gender through an essentialist view (McPhail, 2004), so mental health professionals often have these essentialist beliefs as well. There is a limited amount of research on mental health professionals' conceptualization of gender nonconformity and also about transphobia towards and stereotypes about gender nonconforming individuals who may not identify as transgender. This thesis seeks to further explore the way in which mental health professionals conceptualize gender nonconformity utilizing queer theory as a theoretical framework.

Chapter 1

Problem Statement

Individuals' biological existence determines sex; people are born male-bodied (referred to as male), female-bodied (referred to as female), or intersex. Gender is a socially constructed identity that is assigned to people based upon biological sex. In mainstream culture, gender is split into binary categories. Female-bodied people are conditioned to be girls and then women, and male-bodied individuals are conditioned to be boys and then men. People who do not fit into those categories (referred to here as "gender nonconforming") are stigmatized and discriminated against (Rees-Turyn, Doyle, Holland, Root, 2012). The problem of transphobia against people who are or appear to be gender nonconforming is pervasive. They often face violence, estrangement from family, and other forms of discrimination. This oppression of gender nonconforming individuals often leads them to have negative physical and mental health (Willoughby et al, 2010). They are a largely misunderstood group of people. Mental health professionals are not exempt from misunderstanding and judging them. Mental health professionals who are not educated about gender and sexuality often have transphobic beliefs (Willoughby et al, 2010). Stereotypes and biases held by mental health professionals can limit one's ability to fully understand a client and can potentially cause unintended psychological harm. Without understanding where a client is coming from, mental health professionals are unable to help empower that client (Mallon, 1999).

With the diagnosis of Gender Identity Disorder still included in the current Diagnostic and Statistical Manual of Mental Disorders, discrimination against those who are gender nonconforming is still accepted among mental health practitioners (Lev, 2005). This diagnosis is defended by some who say that it helps to validate the experience and existence of those who are

gender nonconforming. Many practitioners and gender nonconforming people feel this diagnosis is necessary in order to assure access to proper treatment in regard to billing insurance companies. Others argue that it is pathologizing gender nonconformity and is a form of social control, and it seeks to disempower people and perpetuate discrimination (Lev, 2005). In “Mutilating Gender,” Dean Spade recounts his experience as a person who falls in between genders. He explains that professionals judged him as not being “truly” transsexual because he was not fully committed to becoming a man even though he did not want to be a woman, so they would not approve of his wish to transition his body to male. (Spade, 2006). This is one example of how Gender Identity Disorder can be exclusionary and cause professionals to judge peoples’ experiences (Lev, 2005). Spade had an identity placed upon him and identities should be avoided all together unless people claim an identity themselves (McPhail, 2004).

Much of this discrimination is caused by essentialist beliefs (McPhail, 2004). Essentialism is a discourse that uses categories of identity to place people into groups. Once those groups are formed, they then seek to advance their rights within their groups (McPhail, 2004). For example, several organizations have formed to advance the rights of Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals. These organizations have formed because of these identities, and they seek to improve the rights of the individuals fitting into these identities. These identity politics place stigma on bodies and identities, and they are divisive because once something is considered an identity, it is politicized (Warner, 1999). Although this type of discourse is the popular one, it causes people to judge what type of person makes up an identity. It is exclusionary to some people, and to others it places them into categories of identities they do not want to be included in. In this situation, people who are gender nonconforming are often considered transgender when they do not feel that they are, and

they are often victims of transphobia even if they are not transgender (McPhail, 2004). In the field of social work, identities are often focused on in order to serve individuals who are oppressed by their identities (2004). Because of this focus on identities in social work, much of the literature regarding gender nonconforming individuals focuses heavily on identity (transgenderism, gender identity disorder, etc.).

Currently, the literature is mixed about how to respond to the problem of transphobia among mental health professionals. Since social workers and other mental health professionals are often educated through an essentialist perspective (McPhail, 2004), continuing to educate them about gender and sexuality through identity-based politics is often accepted. Some advocate for the diagnosis of Gender Identity Disorder to be kept in the DSM but many others want this diagnosis removed (Ehrbar, Witty, Ehrbar, and Bockting, 2008). McPhail argues for social work to adopt a queer perspective on gender nonconformity while still allowing for personal identity formation. She believes that this view will empower clients outside of identity politics. In other words, it will allow clients to be the best human beings they can be instead of the best transgender people they can be (McPhail, 2004). Service agencies should seek to make their services available to individuals with all types of identities while still understanding that certain people are oppressed by socially constructed identities (Sennott & Smith, 2011). Even though identities are social constructions, they are very real in the world that we live in, so the oppression, shame, and pride experienced by individuals with marginalized identities is very real as well (McPhail, 2004). Using Mcphail and Spade's perspectives, this study hypothesizes a relationship between transphobic beliefs and the way mental health professionals conceptualize and understand gender nonconformity.

Chapter 2

Literature Review

Understanding of Gender Nonconformity

As previously discussed, McPhail (2004) discusses the fact that identity politics are often the focus of social work education because social workers often work with individuals that are part of a marginalized group of people. The focus on identity politics is problematic because it can often perpetuate discrimination due to the focus on specific identities rather than the whole person. It can also be problematic because identities box people into binary categories, and this can end up excluding people. McPhail explains that queer theory, transgender individuals, and sex researchers can teach social workers to conceptualize gender nonconformity in a way that will help them practice more effectively. She explains that queer theory views sexuality and gender as social constructions.

Queer or postmodern theorists critique essentialism and challenge the notion that any of our culture's understandings of sexuality and gender are "natural." They shed light on how once something becomes an identity, it becomes a political institution that can then be persecuted or discriminated against. Finally, they argue that identities and identity politics are regulated by the state through institutions such as education, marriage, the family, etc. They argue that our culture needs to conceptualize gender in a new way that is less focused on binary categories.

Transgender individuals offer their stories of gender and sexual fluidity. Their lives show that the socially constructed beliefs about sex and gender cause them to be viewed as outside the norm because they are one sex and a different gender. They also offer insight into the importance of defining themselves and their own gender instead of accepting identities placed upon them. Sex researchers have recently offered empirical evidence that sexuality is far more fluid than our

society believes or accepts (Hyde & Durik, 2000, Rust, 2000, Diamond and Savin-Williams, 2000). Much of this research focuses on the ways that people might identify with several different identities instead of just one. Finally, McPhail bridges the gap between theory and practice by offering recommendations for social work such as teaching gender and sexuality as continuums, teaching a more inclusive, empowering, and less essentialist language, teaching social workers to question their own belief systems about sexuality and gender, critiquing the pathologization of gender nonconforming individuals, and allowing clients to define their own sexuality.

Sennott and Smith (2011) describe a workshop for clinicians that taught clinicians how to work with gender nonconforming clients using a transfeminist approach that incorporated a similar approach to the one that McPhail proposes. This transfeminist approach acknowledges that identities are social constructions, but the oppression faced by those with marked identities is very real. The beginning of the workshop began with an education on continuums of identities. These identities were sex, gender, gender expression, and sexuality. Next, the clinicians were taught a transfeminist approach for working with clients. The transfeminist approach focuses on the fact that gender is socially constructed, so no gender is more real or privileged than another gender, and there is no way to define a particular gender because these meanings are different for each individual. Finally, the transfeminist approach acknowledges that gender nonconforming individuals are often discriminated against because they have lived at some point during their lives as a woman and have fallen victim to sexism. Clinicians using this model should avoid using essentialist language, should allow clients to define their sexual orientation and gender identity instead of having an identity placed upon them, and should avoid pathologizing their clients.

Two tools were introduced at the workshop for therapists to use with clients. The Transfeminist Qualitative Assessment Tool (Sennott, 2011) was given to clients by therapists using the transfeminist approach. This tool helps therapists understand how clients conceptualize their gender based upon their own lived experiences. The Allyship Practice Model (Sennott, 2011) offers therapists guidelines for using a transfeminist approach. Finally, Sennott and Smith discuss expressed fears by clients and clinicians. Clients' main fears are that they will be judged, discriminated against, or expected to educate their clinician about gender identities when seeking treatment. These fears stem from the fact that this population has historically been discriminated against by medical and mental healthcare providers. Clinicians' main fears were that they were uneducated about gender nonconformity and would be unable to practice effectively because of this. This workshop and the transfeminist approach offered clinicians a way to empower themselves to competently treat gender nonconforming individuals.

Wylie, Corliss, Boulanger, Prokop, & Austin (2010) focused on socially assigned gender expression. They used semi-structured interviews to adapt a two-question questionnaire that measures socially assigned gender expression. Then they tested discriminant validity of the questionnaire. A total of 82 interviews were included in the study, and the mean age of participants was 23.8 years. Of the participants, 22% identified as transgender, 70% identified as something other than heterosexual, and 62% were white. Participants completed the questionnaire and were interviewed about the questionnaire afterwards. The questionnaire ended up being easy to understand, but 42% of participants struggled when having to categorize themselves for the purpose of a one-answer question. They revised the questionnaire and added the words "on average" to the questions. Some participants viewed extreme masculinity or

femininity to be positive, and others saw it as negative. This questionnaire is appropriate for public health surveys to monitor social gender policing.

The diagnosis of Gender Identity Disorder is one way to understand gender nonconformity. Ehrbar, Witty, Ehrbar, and Bockting (2008) completed an exploratory study that assessed clinicians' judgment in diagnosing Gender Identity Disorder (GID) in children. They began by explaining that the diagnosis of GID is something that is controversial because many people believe that this diagnosis makes people who are gender nonconforming seem pathological. Their study sought to understand how clinicians come to diagnose children with GID. They focused on how clinicians' might view gender nonconforming kids as more pathological than gender conforming children, and how they may make the diagnosis when unnecessary (when children are not even gender dysphoric). It also assesses how clinician characteristics may contribute to their decisions about diagnosis. They used a convenience sample of 73 licensed psychologists. The psychologists were randomly given six different clinical vignettes. Some of these vignettes met qualification for diagnosis of GID while others did not. They were then given a questionnaire that asked about diagnoses and General Assessment of Functioning score for their assigned vignette. Other questions asked about clinician demographics. They found that gender nonconforming children and gender conforming children were seen by these clinicians as functioning at about the same level unless the child was experiencing gender dysphoria. They expected to find an over diagnosis of GID, but they actually found an under diagnosis. This may be due to clinician beliefs that GID should be removed from the DSM. They concluded that there is limited knowledge about GID as a diagnosis, and that the diagnosis itself needs to be reformed. They called for future research with a larger sample.

Research on Trans-Identified Individuals

Erich, Tittsworth and Kersten's (2010) research focused on social support for transsexuals, or people who wished to change their genitals to make their bodies congruent with their gender and/or desired sex. This is a comparative study on the experiences of transsexuals of color in comparison to white transsexuals in regards to personal well being, social support networks, and the influence of social support networks on social well being. A questionnaire was completed by 108 participants, 45 of whom were transsexuals of color, and 63 of whom were white transsexuals. Participants were recruited using snowball procedures. This questionnaire included questions about demographics, personal well being (using the Satisfaction With Life Scale and the Index of Self-Esteem), and questions about family relationships. In general, both respondents of color and white respondents received high levels of support from partners, friends, and family when they came out as trans, but friends were the most supportive group. Participants averaged a high score on the life satisfaction scale. Social support was positively correlated with personal well-being. Transsexuals of color had higher levels of support from their intimate partners and from friends than white transsexuals. Previous research has shown the experiences of transsexuals of color and white transsexuals to be different because transsexuals of color experience institutional discrimination from both their racial identity and their gender identity. Nevertheless, self-esteem levels showed to be about the same in both groups. Limitations to this study include the fact that snowballing was used to reach participants and social desirability bias may have come into play when participants completed the personal well being questions.

Factor and Rothblum (2007) were interested in learning about transmen, transwomen, and genderqueer people's demographics, perceived social support, and experiences of violence in comparison to their non-trans siblings. The authors hypothesized that trans-people would be

less educated, have lower levels of employment, less social support, and experience more violence than their non-trans siblings. Questionnaires were completed by 295 participants ranging from 18-72 years old. Questions regarded demographics, social support (The “Perceived Social Support from Friends and Family Questionnaires” were used to measure social support), and experiences of violence/discrimination. Trans-people were recruited through flyers and obtaining people’s email addresses at political, social and other events specifically for trans-people, and they then recruited their non-trans siblings. The mean age of respondents was 35.6, and racial minorities were largely underrepresented. Trans-people were less religious, more educated, and underemployed compared to their non-trans siblings. Trans-people were also more likely than their non-trans siblings to have experienced violence, discrimination, and harassment. In regards to social support, significantly more non-trans siblings had intimate partners than trans-people, and they also had been in their relationships for a longer amount of time. Perceived social support outside of the family was not significantly different for any group, but inside of the family, non-trans siblings received more social support than trans-people. Finally, transmen lived further (geographically) away from their parents than any other group. The authors report that their greatest limitations were that some trans-people did not participate because they did not want to involve their siblings, underrepresentation of racial minorities, and that this study did not account for the fact that individuals’ experiences change over time.

Nemoto, Bödeker, and Iwamoto (2011) completed a descriptive study on transgender women (male to female) with a history of sex work (THSW). Experiences of violence, transphobia, and perceived social support were examined (specifically how these variables relate to depression), and the percentage of people of color that participated was representative of the population. Structured interviews were used for data collection. Fifty percent of participants

reported having been assaulted (over thirty three percent had been raped), and more than fifty percent had experienced suicidal ideation in the past. Sixty-seven percent of participants had been put down by family members for being transgender, and almost all participants had experienced some form of transphobia during their lives. White and Latina THSW reported lower levels of family support than other racial groups reported. These two racial groups also showed a need for more social support. Still, each racial group reported that they were satisfied with their social support overall. All of the variables studied (violence, transphobia, and social support) correlated with depression. A limitation to this study was social desirability bias. The authors call for population-based research, and also research on resilience against transphobia, violence, and mental health issues to be done in the future.

Shipherd, Green, and Abramovitz (2010) did a quantitative study that explored the barriers that transgender individuals face when seeking mental health treatment. A total of 130 transgender individuals were recruited from a conference in Boston, Massachusetts. Participants completed an anonymous questionnaire regarding demographics, physical and mental distress, healthcare history, barriers to accessible healthcare, and treatment preferences. In order to measure barriers to accessible healthcare in this study, the Service Utilization Barriers Scale was developed for this study by the authors. This study found that many transgender individuals were in need of mental health services but were not seeking out services. They found that most participants who accessed services in the past year reported needing these services for issues that were unrelated to their gender identity and could therefore be offered by any practitioner, not just those that are educated about gender. Still, 50% of participants reported receiving counseling for their gender identity at some point in their lives. They found that a barrier to treatment was provider ignorance about transgender experiences, so educating practitioners could help

minimize this barrier. The biggest barrier to services in this sample was the cost of treatment despite the fact that most participants (95%) had health insurance. The authors concluded that this was due to participants' assumptions that insurance companies would not cover mental health services or because they chose providers not covered by their insurance. Finally, the authors called for outreach efforts on the part of practitioners and further research on access to mental healthcare for transgender individuals.

In sum, there is a growing amount of research on transgender individuals, but a lot of this research does not include people who are gender nonconforming unless they identify as trans. This excludes many individuals who deal with a lot of the same discrimination and barriers that trans-identified individuals face. The research cited shows that, for trans-identified individuals, social support is key to resilience. Since it is the responsibility of mental health professionals to help their clients access social support, it is imperative that they understand the unique barriers that gender nonconforming people face.

Research on Transphobia

Hill and Willoughby (2005) completed a quantitative study to create a scale to measure transphobia. They tested it on three different groups of people. The first group was made up of 227 volunteer undergraduate students at a university in Canada. They used this study to develop the Genderism and Transphobia Scale. Their next study tested the reliability and validity of this scale. They wanted to decipher whether the questions in their scale did, in fact, measure transphobia as it exists currently, and also whether it could be used to measure attitudes towards gender nonconforming children as well as adults. The sample they used were 52 parents (34 mothers and 18 fathers) recruited from two community centers in Canada. They were given the Genderism and Transphobia Scale along with Vignettes (Vignette Assessment Questionnaire)

about parent attitudes toward gender nonconforming children. They found the Genderism and Transphobia Scale to have internal reliability and high internal validity. They found gender conforming children to be less pathological than gender nonconforming children. Their third study tested the Genderism and Transphobia Scale on a larger and more diverse sample. They used 180 undergraduate and graduate students at a university in Canada. Participants were given the Genderism and Transphobia Scale along with several other measures that understood their self-esteem, gender identity/expression, personality, and attitudes towards gender nonconformity. They found more intolerance for gender nonconformity with this more diverse sample. They found relatively strong levels of reliability and validity. In sum, this study created the Genderism and Transphobia scale and found that it has relatively high levels of reliability and validity. They call for future testing of their instrument on larger samples.

Willoughby et al (2010) completed a multinational study to further test the reliability and validity of the Genderism and Transphobia Scale; they wanted to understand whether it could be used on different populations and cultures. They also sought to understand what contributes to the formation of transphobia. They completed four separate studies. The first study tested the Genderism and Transphobia Scale on mental health professionals and trainees in the United States. There were 88 participants, and they completed an online survey. They were given the Genderism and Transphobia Scale, a demographic questionnaire, and a multiple choice test of participants' knowledge about transgender individuals. They found that mental health professionals that had been exposed to transgender individuals were more likely to have a greater knowledge about them. They also found that this group of professionals had relatively low levels of transphobia.

The second study (Willoughby et al, 2010) sought to understand value and belief systems that transphobic people may have. They had a sample of 138 people (114 women, 22 men, 2 did not specify a gender) from the United States, recruited from Internet ads. They were given scales that measured respondents' perceived threat to social cohesion, social conformity versus autonomy, a modified version of the Genderism and Transphobia Scale, and a scale regarding attitudes towards transsexualism. They found that higher levels of social conformity predicted transphobic attitudes, but perceived threat to social cohesion was not a predictor of transphobia in this study.

The third study (Willoughby et al, 2010) questioned whether the Genderism and Transphobia Scale is appropriate for use in the Philippines. They used a sample of 207 undergraduate students in the Philippines. They were given the Genderism and Transphobia Scale along with questions about gender variance, sexual orientation, having transgender friends, and their religiousness. They found that the Genderism and Transphobia Scale seemed to be reliable and valid. They also found that there were stark differences in attitudes among male and female participants, finding males more transphobic than females. Gender identity and sexual orientation also influenced attitudes in that people who identified as heterosexual and gender conforming scored significantly higher on the Genderism and Transphobia Scale. Also, they found that more religious people also had higher levels of transphobia. Finally, attitudes of Filipino individuals were very different than those of individuals in the United States because of cultural values such as frowning upon violence, so there was low acceptance for violence against trans-people but high levels of transphobic beliefs.

The fourth study (Willoughby et al, 2010) sought to understand how individual characteristics lead to transphobic beliefs. Their sample was made up of 180 students at a

university in Canada. Participants were given the Genderism and Transphobia Scale along with questions regarding demographics, self-esteem, ego-defensiveness, masculinity, religious fundamentalism, authoritarianism, moral dogmatism, homophobia, and gender role beliefs. They found that gender was a predictor of transphobia (men were more likely to be transphobic than women). They also found that individuals' basic beliefs and values (religion, identity, homophobia) were a predictor of the level of transphobia they would report. The study calls for further research on what leads to transphobia.

Research on client input regarding Gender Identity and Expression

Saltzburg and Davis (2010) completed a qualitative study to understand the way in which gender nonconforming youths understand their gender identity and sexuality. They focused on the new languages used and how that language helped the individual to understand their experience. They attended a peer-lead gender queer discussion group and audiotaped responses to two questions regarding language and how this language has shaped the individuals' lives. The audiotapes were transcribed and then they found themes in the responses. They found that the participants struggled with the language currently used in mainstream culture regarding sex and gender because it often leaves them out or makes them feel misunderstood and/or stereotyped (e.g. assuming a preferred pronoun). Many participants also expressed that the language they use to understand themselves accounts for gender and sexual fluidity whereas popular language does not. They expressed the fact that having a community of gender nonconforming individuals to talk to about gender has helped them understand their own gender, and it helps to validate their experiences and existence. Many trans-identified individuals felt that their transgender identity was important for people to know so that people could know their whole experience. The authors stated that it is very important to allow individuals to define their

own experiences, and they called for updated/more education for mental health professionals on gender and the importance of language.

The Current Study

One of the biggest gaps in the available research is the lack of research available that studies gender nonconformity and transphobia using a queer framework. The current study utilizes some measures used in the existing research to understand transphobia in mental health professionals. This study is different from existing studies in that, as previously discussed, it uses a queer perspective to understand gender nonconformity and transphobia in mental health professionals. Therefore, it builds upon previous research, but it resists using language and measures that are essentialist in nature. This research is relevant to the field of social work because it attempts to shed light on any problematic assumptions about gender that mental health professionals may have, and it will give a frame of reference to those interested in reforming social work education surrounding topics relating to gender nonconformity.

Chapter 3

Conceptual Framework

Theoretical Framework and Purpose of Study

Queer theory stands that essentialism has led our culture to form identities with which to categorize groups of people. This identity formation, in turn, led to judgments, pathologization, and stigma of individuals that have marginalized identities. In regards to gender nonconformity, these factors then led to a transphobic culture. A transphobic, identity based culture has led to a lack of education of social workers and other mental health professionals and ineffective practice with people who are gender non-conforming (Sennott & Smith, 2011, and McPhail, 2004). Much of the social work literature that is available does not acknowledge the existence of essentialism as a problem in social work.

This research used McPhail's perspective of applying queer theory to social work (McPhail, 2004). The study was inclusive of understanding and beliefs about all persons that are gender nonconforming or are perceived to be gender nonconforming. It sought to understand social workers and other mental health professionals' conceptualization of gender nonconformity and how the diagnosis of Gender Identity Disorder in the DSM, client input, and participant demographics influence the way mental health professionals conceptualize gender nonconformity. Finally, it examined whether or not this conceptualization was related to transphobic beliefs, biases, and propensity to perpetrate violence against a gender nonconforming individual.

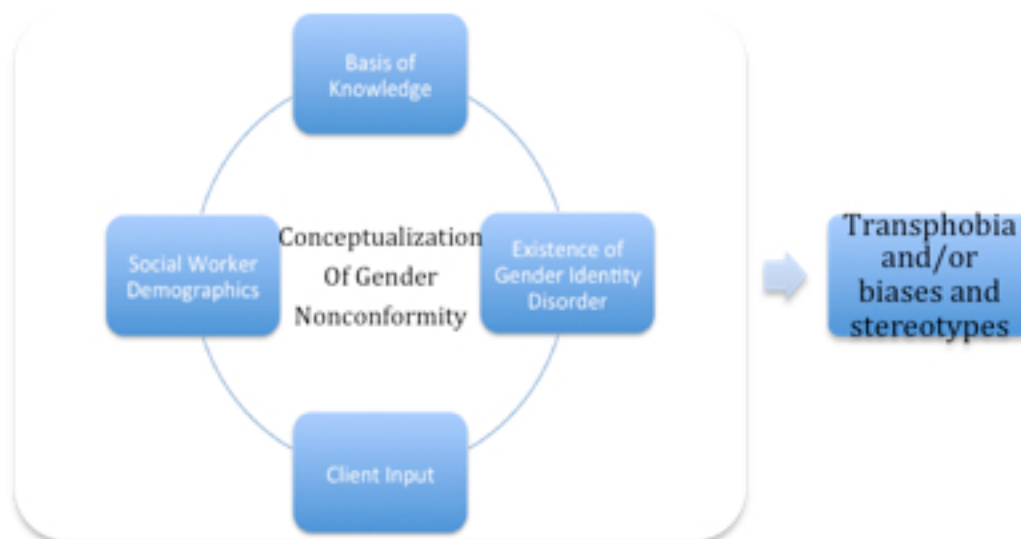
Moreover, the study sought to explore mental health professionals' understanding of gender nonconformity through a lens that does not focus on identity politics but instead on expression and attitudes towards nonconforming gender expressions. It also attempted to

understand whether negative, transphobic beliefs that some mental health professionals hold were associated with an understanding of gender that is essentialist in nature.

This study examined how basis of knowledge, the existence of Gender Identity Disorder, and client input are related to a social worker's conceptualization of gender nonconformity. It also examined whether professionals' understanding of gender nonconformity has any relationship with transphobia. The relationship between demographics and basis of knowledge and an individual's understanding of gender nonconformity were also assessed.

This research is relevant to the field of social work because it sheds light on problematic assumptions about gender that mental health professionals hold, it compares the differences between how social workers conceptualize gender nonconformity and how other mental health professionals conceptualize gender nonconformity, and it gives a frame of reference to those interested in reforming education surrounding topics relating to gender nonconformity. The conceptual framework is depicted in Figure 1 below.

Figure 1: Conceptual Framework



Research Question

This research sought to answer the following question: How do mental health professionals conceptualize gender nonconformity in terms of the types of knowledge and understanding that they have about gender nonconformity? The primary research question was answered by the following sub-questions:

1. How does social workers' conceptualization of gender nonconformity compare with those of mental health professionals from other disciplines?
2. Does the way in which mental health professionals conceptualize gender nonconformity relate to any transphobic beliefs that mental health professionals may or may not express?
3. Does the existence of Gender Identity Disorder in the DSM relate to mental health professionals' conceptualization of gender nonconformity?
4. What role does client self-identification play in how mental health professionals conceptualize and/or define the clients' gender identity?
5. How are mental health professionals' demographics (age, education level, gender identity, gender expression, and/or sexual orientation) related to conceptualizations of gender nonconformity?

Chapter 4

Methodology

Research Design

This exploratory research used a cross-sectional, non-experimental, correlational survey research design. The exploratory nature of this study allowed for a greater understanding of how mental health professionals conceptualize gender nonconformity. It is a correlational study because it tested for a relationship between mental health professionals' understanding of gender nonconformity and their level of transphobia. The research was approved by The Ohio State University Institutional Review Board.

Independent Variables

There are several variables in this study. The major independent variable is conceptualization of gender nonconformity. The operational definition of 'conceptualization of gender nonconformity' reflects the kind of knowledge that social workers have regarding variance in gender expression among their clients. This variable was measured by asking questions that assess the basis of knowledge that mental health professionals have about people who are gender nonconforming. Basis of knowledge means the perspective with which an individual uses to build upon their understanding of gender nonconformity. This could be an essentialist perspective, a queer perspective, or something else entirely. Other variables that were studied include understanding of gender nonconformity are demographics, the existence of Gender Identity Disorder in the DSM, and client input about their gender identity. Demographics studied were age, religion, gender identity, gender expression, and sexual orientation and were measured by asking questions about how the participants identify with each demographic. The influence that the existence of the diagnosis of Gender Identity Disorder and client input have on

how mental health professionals conceptualize gender nonconformity were measured by asking how much mental health professionals take clients' own way of identifying into consideration when deciding on diagnosis and treatment.

Dependent Variables

The major dependent variables in the study are transphobia, stereotypes, and biases. The operational definition for transphobia "is an emotional disgust toward individuals who do not conform to society's gender expectations" (Hill & Willoughby, 2005). This was measured using a previously created scale that has been adapted adapted for use on mental health professionals for this research.

Measurement and Instrumentation

This study utilized quantitative data collection methods in order to examine relationships between several variables described below.

1. Demographics – Participants were asked several general demographic questions in order describe the sample and to study relationships between personal demographics and other variables being studied. The specific demographic variables that were assessed were credentials/professional title, age, religion, sexual orientation, gender identity, and sex identity. Other questions in the demographics section of the questionnaire assessed experience with gender nonconformity. The first question was, "Would you describe yourself as gender nonconforming?" "Have you ever worked with a gender nonconforming client?" and "Do you feel that you are educated on the transgender population?" Participants were asked to choose "Yes," "No," "Sometimes," "I don't know," or "Prefer not to say." The other two questions were, "Have you ever worked with a gender nonconforming client?" and "Do you feel that you are educated on the

transgender population?” Participants were asked to choose, “Yes,” “No,” “I don’t know,” or “Prefer not to say,” to answer each of these questions.

2. Knowledge about Gender Nonconformity – Questions regarding the kind of knowledge mental health professionals have regarding gender nonconformity were assessed in order to answer the research question and examine relationships between knowledge about gender nonconformity and other variables studied. These questions were, “Do you believe there are only two genders?” and “Do you have a good understanding of the difference between sex and gender?” Participants were asked to choose, “Yes,” “No,” “I don’t know,” or “Prefer not to say,” to answer these questions.

The belief that there are only two genders is a belief that is essentialist in nature because it forces individuals into the binary identity categories “man” or “woman” (McPhail, 2004). If a practitioner believes that there are only two genders, a gender nonconforming individual that receives services from this practitioner might feel misunderstood and might be mislabeled. Therefore, asking participants whether they believed that there are only two genders allowed the researcher to understand whether participants had knowledge about gender nonconformity that was essentialist in nature. Understanding the difference between sex and gender is a basic concept, but it is important to know in order to understand the experience of gender nonconforming and/or transgender individuals. Therefore, asking participants whether they have a good understanding of the difference between sex and gender allowed the researcher to understand if participants had a basic understanding of gender nonconformity.

3. Gender Identity Disorder – Participants were asked questions regarding their perceptions and beliefs about the diagnosis of Gender Identity Disorder in order to understand

whether this disorder is related to how mental health professionals conceptualize gender nonconformity. Participants were asked to choose “Yes,” “No,” “I don’t know,” and “Prefer not to say,” to the questions, “Do you believe Gender Identity Disorder should be included in the DSM-V?” and “Would you assume that a client had Gender Identity Disorder because they appeared to be gender nonconforming?”

4. Client Input – Participants were asked questions regarding how they would respond to gender nonconforming clients’ input about their gender expression and identity in order to study whether client input is related to mental health professionals’ conceptualization of gender nonconformity. Participants were asked to choose, “Yes,” “No,” “I don’t know,” and “Prefer not to say,” to the following questions: “If a gender nonconforming client used terminology that was unfamiliar to you to describe their gender identity, would you use that terminology to describe the person as well, even if you disagreed with it or it made you uncomfortable?”, “Would you describe a gender nonconforming client as transgender even if without that self-identification?”, “Would you ask what pronoun a gender nonconforming client preferred and then use that pronoun when referring to the person\ (He/She/Hir/They, etc.)?”, and “If you had a gender nonconforming client, would you ask how the person identified (Man, Woman, Trans, Queer, etc.)?”
5. Transphobia – One previously used scale for assessing transphobia is called the “Genderism and Transphobia Scale” and has been used to measure transphobia in several different populations (Willoughby et al, 2010 & Hill & Willoughby, 2005). This is a good scale in several ways. It has previously been validated and used on several different populations in several different countries. It also has two different subscales. One is a Genderism and Transphobia subscale which measures transphobic beliefs, and one is a

Gender Bashing subscale which measures the propensity to perpetrate violence against a transgender individual.

However, this scale is limited in several ways. First of all, it only measures transphobia against those who are transgender and/or transsexual (Hill & Willoughby, 2005) instead of anyone who is or is perceived to be gender nonconforming. Next, although it has been used to measure beliefs of mental health professionals (Willoughby et al, 2010), it is more appropriate for use on the general population than on professionals. With permission from the authors, this research adapted the Genderism and Transphobia Scale and created a revised measure of assessing transphobia that included questions about all gender nonconforming people and is more appropriate for measuring the beliefs of mental health professionals. This allowed for a greater understanding of the beliefs that social workers and other mental health professionals have about gender nonconforming people and how those beliefs are shaped by their conceptualization of gender nonconformity. This scale is made up of 32 Likert-type scale questions.

Data Collection Procedure

A questionnaire was used to collect data. The questionnaire included three sections. The first section asked demographic questions. The second section asked questions regarding basis of knowledge about gender, questions regarding beliefs about Gender Identity Disorder, and questions about regard for client input. This section was personally developed and piloted on a peer. The peer was appropriate for piloting this instrument because this individual works in the mental health field. The third section assesses transphobia by using a revised version of the Genderism and Transphobia Scale. This scale has been adapted to include all gender nonconforming people (and not just trans identified people), and to be made appropriate for use

on social workers working in the field of mental health. Most questions in this questionnaire are nominal multiple-choice questions or ordinal Likert-type scale questions, but some are continuous variables. There was also a space for comments at the end of the questionnaire. The questionnaire is attached [Appendix A].

The questionnaire was available online and in paper form. Participants were provided with a stamped envelope that was addressed to the researcher in order to assure that their answers were anonymous. The online questionnaire utilized Lime Survey which is a software tool that stores data on a firewall-protected server housed in the College of Social Work in order to ensure anonymity of participants. Only research personnel have access to the data.

Sample

This research utilized non-probability, convenience sampling. Participants were recruited by attending a monthly clinical directors meeting at which several clinical directors from 14 agencies throughout Columbus, Ohio attend. Each of these agencies offer services to individuals of all ages, they each offer mental health treatment for a wide range of issues, and they each employ social workers among other mental health professionals to provide services. Although this sample may not be representative of the general mental health professional population, this study piloted an adapted measure that can continue to be tested for external validity in the future.

At the clinical directors meeting, the researcher explained the research to the clinical directors [Appendix B]. They were informed that participation was voluntary and that questionnaires were available in both a paper and an online format, and participants had the option of completing the format that they preferred. A total of 200 questionnaires were then distributed to the clinical directors. The clinical directors took them to their respective agency and distributed the paper questionnaires, consent information [Appendix C], and link to the

online questionnaire to their employees. Attached to the questionnaire was a recruitment letter that explained the research to potential participants [Appendix D]. Participants were offered an incentive for participating to gain interest. The incentive was a raffle for one of seven \$50 gas cards. Inclusion was based upon whether participants were mental health professionals with at least a bachelor's degree. No identifying information was asked. Data was collected in February and March of 2013. Of the 200 questionnaires distributed, 64 were completed and returned for a 32% response rate. The response rate achieved was consistent with that of prior research and electronic surveys (Cook et al, 2000).

Data Analysis

Data was entered into IBM SPSS software for statistical analysis. Frequencies were run on responses to demographic questions and questions that measured knowledge about gender nonconformity, gender identity disorder, and client input in order to examine how many participants chose each response category. In order to measure levels of transphobia, responses to questions on the Genderism and Transphobia Scale were totaled. Total Genderism and Transphobia Scale score, genderism and transphobia subscale score, and gender bashing subscale score were measured along with participant means of each scale/subscale score. Several one-way ANOVAs and independent sample t-tests were run in order to determine whether there was a significant difference in scores on the Genderism and Transphobia Scale depending on responses to other variables studied. Several cross-tabulations were run in order to understand if there was a significant difference in responses depending on how participants responded to other variables measured.

Conceptualization of Gender Nonconformity in Relationship to Variables

As noted above, in order to answer the main research question, the questionnaire completed by mental health professionals was designed to answer several sub-questions. Table 1 depicts the variables analyzed to answer each sub-question, and Table 2 depicts these variables and the survey items relevant to each variable.

Table 1

Sub-Questions and Variables Analyzed

Sub-question	Variables Analyzed
How does social workers' conceptualization of gender nonconformity compare with those of mental health professionals from other disciplines?	<ul style="list-style-type: none"> - Credentials - GTS scores - Responses to knowledge about gender items (Cross-tabs)
Does the way in which mental health professionals conceptualize gender nonconformity relate to any transphobic beliefs that mental health professionals may or may not express?	<ul style="list-style-type: none"> - Responses to knowledge about gender questions - GTS scores
Does the existence of Gender Identity Disorder in the DSM relate to mental health professionals' conceptualization of gender nonconformity?	<ul style="list-style-type: none"> - Responses to GID questions - Responses to knowledge about gender questions - GTS scores
What role does client self-identification play in how mental health professionals conceptualize and/or define the clients' gender identity?	<ul style="list-style-type: none"> - Responses to client identification questions - Responses to knowledge about gender questions - GTS scores
Post Hoc: Is there a relationship between how mental health professionals perceive identities of gender nonconforming clients and how mental health professionals conceptualize gender nonconformity/transphobia?	<ul style="list-style-type: none"> - Responses to perceptions about client identities questions - Responses to knowledge about gender questions - GTS scores
How are mental health professionals' demographics (age, education level, gender identity, gender expression, and/or sexual orientation) related to conceptualizations of gender nonconformity?	<ul style="list-style-type: none"> - Responses to demographics questions - Responses to knowledge about gender questions - GTS scores

Table 2

Survey Items Relevant to each Variable

Variables	Relevant Survey Items
Demographics	<p>“What is your professional title/credentials?”</p> <p>“How old are you?”</p> <p>“What religion, if any, do you identify with?”</p> <p>“What is the sexual orientation that you most identify with?”</p> <p>“What is your sex identity?”</p> <p>“What is your gender identity?”</p> <p>“Would you describe yourself as gender nonconforming?”</p> <p>“Have you ever worked with a gender nonconforming client?”</p> <p>“Do you feel that you are educated on the transgender population?”</p>
Knowledge about Gender	<p>“Do you believe there are only two genders?”</p> <p>“Do you have a good understanding of the difference between sex and gender?”</p>
Gender Identity Disorder	<p>“Do you believe Gender Identity Disorder should be included in the DSM-V?”</p> <p>“Would you assume that a client had Gender Identity Disorder because they appeared to be gender nonconforming?”</p>
Client Input	<p>“If a gender nonconforming client used terminology that was unfamiliar to you to describe their gender identity, would you use that terminology to describe the person as well, even if you disagreed with it or it made you uncomfortable?”</p>
Perceptions about Gender Nonconforming Clients’ Identities	<p>“Would you describe a gender nonconforming client as transgender even if without that self-identification?”</p> <p>“Would you ask what pronoun a gender nonconforming client preferred and then use that pronoun when referring to the</p>

	person\ (He/She/Hir/They, etc.)?” “If you had a gender nonconforming client, would you ask how the person identified (Man, Woman, Trans, Queer, etc.)?”
Transphobia	Genderism and Transphobia Scale Genderism and Transphobia Subscale Gender Bashing Subscale

Chapter 5

Results

Demographics of Sample

General Demographics

Table 3 below shows the demographics of the sample. Responses to the question regarding credentials were grouped onto the following four separate categories: Professional Clinical Counselor, Nurse/Medical Doctor, Social Worker, and Other. As Table 3 below shows, the majority of respondents were social workers (59.4%); 18.8% were Professional Clinical Counselors; 4.7% were Nurses/Medical Doctors; and 17.2% reported credentials fitting outside of these categories, so they were categorized as “Other.” Some examples of reported credentials of respondents included in the “Other” category were responses like “BA Education,” “Manager,” and “Employment Specialist.” Respondents were ages 23-70, and the average age for the sample was 43.66 (SD = 12.748). Ages were grouped into two age groups in order to study whether there was a difference in responses between participants who were above the average age of the sample and those that were below the average age (age 43). Using the mean as the split, 48.4% were 43 or older, and 51.6% were below the age of 43. The majority of respondents identified as Christian (60.9%). The majority of respondents (76.6%) identified as heterosexual/straight, 9.4% identified as bisexual, 7.8% identified as gay, 3.1% identified as

lesbian, and 3.1% identified as queer. Female respondents made of 84.4% of the sample, and 15.6% identified as male. No one in this sample identified as transsexual or intersex, or as transgender or genderqueer. This is interesting to note because this study asks questions regarding knowledge about gender nonconforming individuals, some who may identify as transgender/transsexual, and there were no trans-identified individuals in the sample.

Table 3

Respondent Demographics (N = 64)

Variables		Frequencies
Age	> 43	31 (48.4%)
	< 43	33 (51.6%)
Credentials	PCC	12 (18.8%)
	Nurse/MD	3 (4.7%)
	Social Worker	38 (59.4%)
	Other	11 (17.2%)
Religion	Buddhist	3 (4.7%)
	Christian	39 (60.9%)
	None	16 (25.0%)
	Other	3 (4.7%)
	Missing	3 (4.7%)
Sexual Orientation	Heterosexual/Straight	49 (76.6%)
	Bisexual	6 (9.4%)
	Gay	5 (7.8%)
	Lesbian	2 (3.1%)
	Queer	2 (3.1%)
Sex Identity/Gender Identity	Female/Woman	54 (84.4%)
	Male/Man	10 (15.6%)
Self Describe as Gender Nonconforming	Yes	5 (7.8%)
	No	44 (68.8%)
	Sometimes	11 (17.2%)
	I don't know	3 (4.7%)
	Missing	1 (1.6%)
Worked with Gender Nonconforming Population	Yes	56 (87.5%)
	No	6 (9.4%)
	I don't know	1 (1.6%)
	Prefer not to say	1 (1.6%)
Educated on Trans Population	Yes	37 (57.8%)
	No	23 (35.9%)
	I don't know	1 (1.6%)

Prefer not to say	1 (1.6%)
Missing	2 (3.1%)

Experience with Gender Nonconformity

As shown in table 3, the majority of respondents said that they do not describe themselves as being gender nonconforming. A total of 17.2% of respondents reported that they would describe themselves as being gender nonconforming sometimes, and 7.8% reported that they would describe themselves as gender nonconforming. Most respondents (87.5%) of respondents reported having worked with a gender nonconforming client in the past. A slight majority of respondents (57.8%) felt that they were educated on the transgender population. More respondents reported having worked with a gender nonconforming client in the past (n = 56) than those that reported feeling educated on the transgender population (n = 37). Over one-third (35.9%) of respondents reported that they do not feel they are educated on the transgender population.

Knowledge and Understanding of Gender Nonconformity

A total of 14.1% of respondents believed there are only two genders; 65.6% of respondents did not believe that there are only two genders; and 20.3% of respondents reported not knowing. The majority (78.1%) of respondents reported understanding the difference between sex and gender, and 12.5% of respondents reported not understanding the difference between sex and gender.

Genderism, Transphobia, and Gender Bashing

Scores on the Genderism and Transphobia Scale ranged from 32-152. Overall, mental health professionals scored relatively low on the Genderism and Transphobia Scale (m = 51.74) meaning low reported levels of genderism and transphobia and gender bashing. However, there

were a few outliers that scored high on the Genderism and Transphobia scale, reporting high levels of genderism and transphobia and gender bashing. Figure 2 shows the scores on the genderism and transphobia subscale, and Figure 3 shows scores on the gender bashing subscale.

Figure 2

Transphobia Total Scores

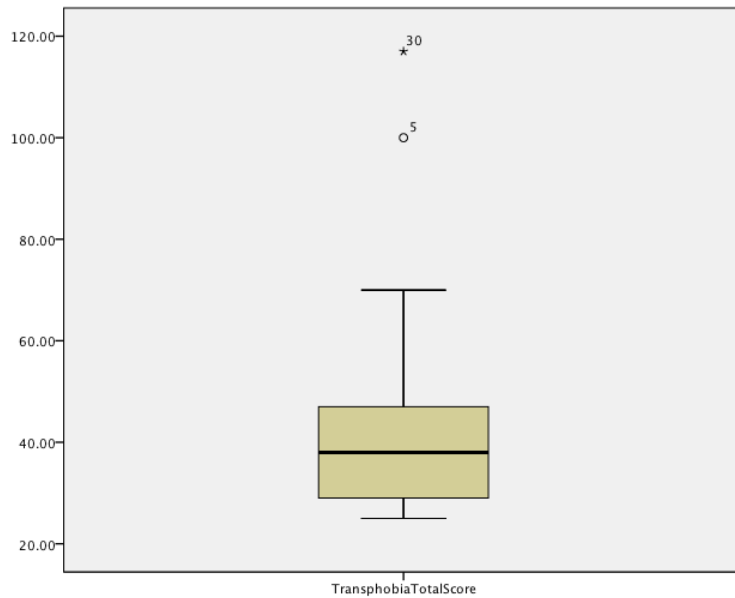
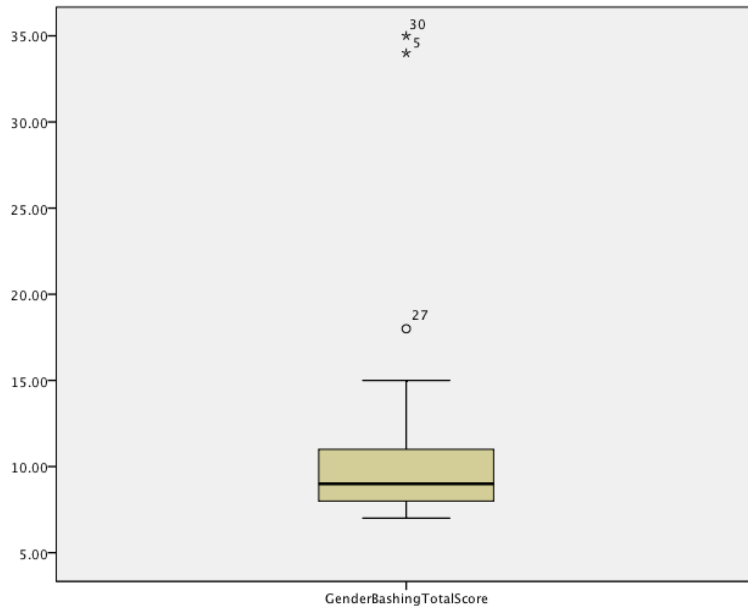


Figure 3

Gender Bashing Total Scores



As Figure 2 and Figure 3 show, scores on both the genderism and transphobia subscale ($M = 41.32$) and the gender bashing subscales ($M = 10.42$) were relatively low meaning low levels of transphobic beliefs and low levels of propensity to perpetrate violence against or feel anger towards a gender nonconforming individual. However, there were a few outliers that reported high levels of transphobia and had a high propensity to perpetrate violence or feel anger towards a gender nonconforming individual.

Social Workers Conceptualization of Gender Nonconformity

The first sub-question is: “How does social workers’ conceptualization of gender nonconformity compare with those of mental health professionals from other disciplines?” To answer this question, data was analyzed from the following questionnaire items. First, credentials were analyzed and split into four groups as noted above. Cross-tabulations of social workers and other mental health professionals’ answers to the Knowledge about Gender questions were run to gain an understanding of how social workers understand gender nonconformity compared with other mental health professionals. The results indicate 5 of the 9 participants who reported

believing there are only two genders were social workers (56%); 6 of the 13 participants who reported not knowing if there are only two genders were social workers (46%); and 27 of the 42 participants who said there are not only two genders were social workers (64%). Differences in the way social workers answered this question compared to other mental health professionals was not significant.

Of the 50 respondents that reported having a good understanding of the difference between sex and gender, 29 were social workers (58%). Of the 8 respondents that reported not knowing the difference between sex and gender, 3 were social workers (38%). All 6 respondents that reported not knowing if they understood the difference between sex and gender or not were social workers (100%). Although this is not statistically significant, it trends in that direction ($p = 0.086$). Next, a one way ANOVA on credentials and scores from the Genderism and Transphobia Scale adapted for mental health professionals was run to gain an understanding of whether social workers had higher or lower levels of transphobia and propensity to have anger towards or perpetuate violence against a gender nonconforming individual. Table 4 below shows the results to this and all other ANOVAs run in this data analysis. Results to this specific test show that, overall, social workers and other mental health professionals responded similarly when asked questions regarding their knowledge about gender nonconformity, transphobic beliefs, and their propensity to perpetuate violence against a gender nonconforming individual ($p > 0.05$) (See Table 4). The majority of social workers and other mental health professionals understand the difference between sex and gender and understand that there are more than two genders. Even still, several reported not having an understanding regarding these concepts. The majority of social workers and other mental health professionals also have low levels of transphobic beliefs

and a low propensity to feel anger towards or perpetrate violence against a gender nonconforming person with the exception of a few outliers.

Table 4

Total Genderism and Transphobia Scale Score

Variable	N	df	F	p
Credentials	61	3, 58	0.781	0.509
2 genders	61	2, 59	7.739	0.001
Sex/Gender	61	2, 59	0.325	0.724
Describe client as Trans	61	2, 59	0.128	0.880
Preferred Pronoun	61	2, 59	0.791	0.378
Ask how client identified	61	2, 59	4.784	0.012
Religion	58	3, 55	2.229	0.095
Sexual Orientation	61	4, 57	1.392	0.248
Self-described GNC	60	3, 57	1.238	0.304
Worked with GNC client	61	3, 58	7.706	0.000

Genderism and Transphobia and Conceptualization of Gender Nonconformity

The second sub-question that the questionnaire sought to answer was, “Does the way in which mental health professionals conceptualize gender nonconformity relate to any transphobic beliefs that mental health professionals may or may not express?” This question was answered by analyzing data from the following items. First, a one-way ANOVA was run on the total GTS scores, Genderism and Transphobia subscale scores, and Gender Bashing subscale scores and the question, “Do you have a good understanding of the difference between sex and gender?” to examine if there was a relationship between understanding the difference between sex and gender and having higher levels of transphobia and gender bashing. Results show that there is

not a significant relationship between understanding the difference between sex and gender and levels of transphobia ($p = 0.724$). This means that mental health professionals in this study did not necessarily have high levels of transphobia if they did not understand the difference between sex and gender.

Next, a one-way ANOVA was run on the total GTS score, the Genderism and Transphobia subscale score, and the Gender Bashing subscale score and answers to the question, “Do you believe there are only two genders?,” to examine if there was a relationship between believing that there are only two genders and having higher levels of transphobia and gender bashing. This analysis tested the hypothesis, “There will be a relationship between believing there are only two genders and scoring higher on the GTS.” Results show that people who believe there are only two genders also reported statistically significant ($p < 0.05$) higher genderism and transphobia scores ($F(2, 59) = 7.739, p = 0.001$), meaning that they had significantly higher levels of transphobia overall. Therefore, the hypothesis was supported, and there is a relationship between believing that there are only two genders and having higher levels of transphobia. The results to both of these ANOVAs are included in Table 4 above.

Gender Identity Disorder and Conceptualization of Gender Nonconformity

The third sub-question that the questionnaire sought to answer was, “Does the existence of Gender Identity Disorder in the DSM relate to mental health professionals’ conceptualization of gender nonconformity?” This question was answered as follows. Cross-tabulations were run comparing answers to questions regarding Gender Identity and questions regarding knowledge about gender nonconformity (“Do you believe that there are only two genders?,” and Do you have an understanding of the difference between sex and gender?”). Overall, results from this research show that there is not a relationship between mental health professionals’ beliefs about

Gender Identity Disorder and mental health professionals' conceptualization of gender nonconformity ($p > 0.05$).

Client Self-Identification and Conceptualization of Gender Nonconformity

The fourth sub-question that this research sought to answer was, "What role does client self-identification play in how mental health professionals conceptualize and/or define the clients' gender identity?" This question was answered as follows. Cross-tabulations were run on responses to the question, "If a gender nonconforming client used terminology that was unfamiliar to you to describe their gender identity, would you use that terminology to describe the person as well, even if you disagreed with it or it made you uncomfortable?" and questions regarding knowledge about gender nonconformity ("Do you believe there are only two genders?" and "Do you have an understanding of the difference between sex and gender?"). The results show that there is not a relationship between client self-identification and how mental health professionals conceptualize gender nonconformity.

However, several other questions from the questionnaire regarding professionals' perception of client identities were asked, and results from those questions were analyzed with results to questions regarding knowledge about gender to test the post hoc question, "Is there a relationship between how mental health professionals perceive identities of gender nonconforming clients and how mental health professionals conceptualize gender nonconformity/transphobia?" In order to answer the research question, "Is there a relationship between perceptions about gender nonconforming clients' identities and having higher levels of transphobia?" several one-way ANOVA tests were run on responses to questions about perceptions about gender nonconforming clients' identities and total GTS scores, Genderism and Transphobia sub-scores, and Gender Bashing sub-scores. Results are included in table 4 above.

Results show that there is not a statistically significant difference in GTS scores between respondents different answers to whether they would ask a client about preferred pronouns and responses to whether they would describe a gender nonconforming client as transgender even without their self identification.

Regarding the question about whether professionals would ask how a gender nonconforming client identified, respondents who reported not knowing if they would ask scored significantly higher on the total GTS scale ($m = 74.667$) compared to the total sample ($m = 51.742$) ($F(2, 59) = 4.784, p = 0.012$). Differences in scores were also statistically significant in these respondents' scores on the Genderism and Transphobia subscale ($F(2, 59) = 4.848, p = 0.011$) and the Gender Bashing subscale scores ($F(2,59) = 3.880, p = 0.026$). However, the differences in scores of respondents that answered yes ($m = 49.431$) or no ($m = 47.800$) to this question is not significantly different from the total score ($p > 0.05$). Therefore, those who reported not knowing whether they would ask clients how they identified had higher levels of transphobia and a higher propensity to perpetrate violence against or feel anger toward a gender nonconforming client than the sample as a whole.

In order to answer the research question, “Is there a relationship between assuming a gender nonconforming client was transgender even without their self-identification and not understanding the difference between sex and gender?” a cross-tabulation was run comparing responses to the questions, “Would you describe a gender nonconforming client as transgender even if without that self identification?” and “Do you have a good understanding of the difference between sex and gender?” Results show that there is a statistically significant relationship in the responses to these two questions ($\chi^2 (4, n = 64) = 20.41, p = 0.000$). This means that there is a negative relationship between making assumptions about a client's identity

or reporting not knowing if they would make assumptions about clients' identities and whether they understand the difference between sex and gender. Therefore, higher levels of assumptions and higher levels of not knowing whether one would make assumptions is associated with lower levels of understanding.

Cross-tabulations on other questions regarding professionals' perceptions of client identity and knowledge about gender nonconformity questions were not significant ($p > 0.05$). Overall, results in this research showed that there is no statistically significant relationship between mental health professionals' perceptions of gender nonconforming clients' identities and knowledge about gender nonconformity. However, there is a statistically significant relationship between respondents not knowing if they would ask a client how they identified and having higher GTS scores. This means that mental health professionals that did not know if they would ask how a gender nonconforming client identified had significantly higher levels of transphobic beliefs and also a higher propensity to perpetuate violence/feel anger towards a gender nonconforming person than the sample as a whole.

Demographics and Conceptualization of Gender Nonconformity

The final sub question that the questionnaire sought to answer is, "How are mental health professionals' demographics related to conceptualizations of gender nonconformity? In order to answer this question, several cross-tabulation tests were run on each of the demographic questions and questions regarding knowledge about gender. Also, one-way ANOVA tests were run on demographic questions and total GTS scores, genderism and transphobia subscale scores, and gender bashing scores in order to examine if there were any relationships between mental health professionals' demographics and their levels of transphobia (Table 4). Overall, most demographics did not have a significant relationship with the way mental health professionals

conceptualize gender nonconformity or with levels of transphobia. Still, a few demographics were significant.

Analyses showed that there was a relationship between age group and how they responded when asked if they understand the difference between sex and gender for this sample. In order to answer the research question, “Is there a relationship between mental health professionals’ age group and whether they understand the difference between sex and gender, the null hypothesis, “There will be no relationship between age group and understanding the difference between sex and gender” was tested. In order to test the null hypothesis, a cross-tabulation was run on age group and responses to the question, “Do you have a good understanding of the difference between sex and gender?” Results show that there is a statistically significant relationship between respondents’ age group and whether they understood the difference between sex and gender ($X^2 (2, n = 64) = 5.83, p = 0.05$). Of the 8 respondents that reported not understanding the difference between sex and gender, 7 were over the age of 43. Therefore, the null hypothesis was rejected.

There was also a relationship between religion and levels of transphobia. In order to answer the question, “Is there a relationship between religious group and levels of transphobia?” the null hypothesis, “There will be no relationship between religious group and level of transphobia” was tested. In order to test the null hypothesis, a one-way ANOVA test was run on responses to the question about religion and GTS total scale score, genderism and transphobia subscale score, and gender bashing subscale score. Results show that differences in total GTS scores and gender bashing scores among religious identity was not significant ($p > 0.05$). However, there was a statistically significant difference in transphobia total scores among Christian participants ($m = 45.9$), Buddhist participants ($m = 32.5$), participants that did not

identify with a religion ($m = 32.5$), and participants that chose “other” for their religion ($m = 34.0$). Christians scored significantly higher than all others on the transphobia subscale ($F(3,55) = 3.33, p = 0.026$). Therefore, the null hypothesis was rejected, and there is a relationship between levels of transphobia and religion.

Chapter 6

Discussion

Summary of Results

Overall, participants scored low on the Genderism and Transphobia Scale adapted for mental health professionals reflecting low levels of transphobia and low levels of gender bashing. Participants that reported believing there are only two genders or not knowing if there were only two genders had higher levels of transphobia than those that did not report believing that there are only two genders. Therefore, there is a relationship between how mental health professionals conceptualize gender nonconformity and transphobic beliefs. Because of this relationship, education on gender nonconformity that provides mental health professionals with a basic understanding of the difference between sex and gender and the idea that gender and sexuality are social constructions that are not static could help lower levels of transphobia in this population. The need for education is further discussed in the education section below.

Next, social workers and other mental health professionals responded similarly to most questions regarding knowledge about gender nonconformity and levels of transphobia. However, 100% of respondents that reported not knowing if they had a good understanding of the difference between sex and gender or not were social workers. Therefore, this research suggests a need for social work education to teach further about the ideas of sex and gender and how they differ. Future research would need to be completed exploring further social workers understanding and beliefs about this population in order to understand differences between social workers and mental health professionals.

Respondents who reported not knowing if they would ask a gender nonconforming client how they identified scored significantly higher on the Genderism and Transphobia Scale

meaning that they had higher levels of transphobia than the sample as a whole. There is also a statistically significant relationship between making assumptions about a clients' identity and whether they understand the difference between sex and gender. Those that reported they would, and those that did not know if they would, describe a client as transgender even if they did not self-identify as transgender were more likely to not understand the difference between sex and gender than those that would not. Therefore, there is a relationship between professionals' perception of clients' identities and transphobic beliefs. In order to address this, education for mental health professionals on gender nonconformity should include information on how they should go about appropriately working with gender nonconforming clients in a way that will not perpetuate the stigma. For example, mental health professionals should be instructed not to make assumptions about client identities (Sennott & Smith, 2011).

This research did not find any significant relationship between the existence of Gender Identity Disorder in the DSM and mental health professionals' conceptualization of gender nonconformity. However, a qualitative study to understand why mental health professionals do or do not believe that this diagnosis should exist and how the existence of this diagnosis impacts what mental health professionals think about gender nonconformity may be necessary in order to explore this variable further. A qualitative study would be helpful in understanding if mental health professionals who believe that Gender Identity Disorder should be kept in the DSM believe this way because they think gender nonconformity is pathological or because of the necessity of this diagnosis for insurance billing purposes, or another reason entirely.

Finally, there were relationships between demographic variables and transphobia scale scores. A statistically significant relationship was found between respondents' age group and whether they understood the difference between sex and gender meaning that more respondents

over the age of 43 reported not understanding the difference between sex and gender than respondents under the age of 43. This could be because gender identity is a social construction, so it is not static and therefore the understanding of it changes over time (Warner, 1999). Since this is so, younger people have grown up with a different understanding of gender identity than older people.

A statistically significant difference was found in transphobia total scores of respondents identifying across religions. Christians scored significantly higher on the transphobia subscale meaning they had higher levels of transphobia than the total sample. The need for education that is sensitive to religious beliefs is addressed in the education section below.

Implications for Social Work

Education

At the end of the questionnaire, there was a space for participants to include any additional comments they wanted to share. Several participants stated they believe education on this population is needed. For example, one participant stated, *“I do feel there needs to be more education regarding this topic. I have recently been working with a greater number of transgender individuals compared to previous years and feel that we all could benefit from more education on how to assist them.”* There are several things to consider in order to provide adequate education on this population to mental health professionals. Because Christians had higher levels of transphobia, education that addresses religious beliefs in a sensitive manner while still attempting to de-stigmatize and de-pathologize the experience of gender nonconforming individuals should be considered. This type of education would take a lot of planning, but it is necessary for mental health professionals to work through their prejudices (regardless of their religious beliefs) in order to practice ethically, so this type of education is

necessary. The importance of education for mental health professionals on the gender nonconforming is also indicated in previous literature. Shipherd, Green, and Abramovitz (2010) concluded that outreach and education on the part of mental health professionals is vital for effectively serving the transgender population (Shipherd, Green, and Abramovitz, 2010). Mallon (1999) reports that it is imperative that social workers develop knowledge about the transgender population in order to practice effectively.

Because this research utilizes a queer theoretical framework, it is important to note that the belief there are only two genders stems from knowledge about gender that is essentialist in nature (McPhail, 2005). Therefore, the relationship between mental health professionals' beliefs that there are only two genders and higher levels of transphobia shows that education on gender nonconformity that focuses less on essentialism could be beneficial to this population. In general, any kind of basic education on gender nonconforming and trans-identified individuals is necessary for mental health professionals. The majority of participants (87.5%) had worked with a gender nonconforming client in the past, but only 57.8% reported they feel they are educated on the transgender population. This is concerning because, as noted in the literature, gender nonconforming individuals come into contact with mental health professionals at a higher rate than the general population (Shipherd, Green, & Abramovitz, 2010). Therefore, mental health professionals should be educated on this population in order to provide services to this population in an effective, competent manner.

Limitations

There were several limitations to this study. First of all, the sample size was relatively small, and because convenience sampling was used, the sample studied is not representative of the mental health professional population as a whole. Next, social desirability bias may have

been a factor in the way participants responded to questions. The subject matter of this research concerns personal beliefs about professional practice, and participants may have felt the need to make themselves seem more accepting than they might have been. This may be why there were so many “I don’t know” responses chosen to some questions. Participants might have wanted to say the “right” thing instead of the answer that was true, and they might not have known the “right” thing to say, so they chose “I don’t know.” Future related research should take social desirability bias into account.

Suggestions for Future Research

As suggested above, a qualitative study about Gender Identity Disorder could help to understand what impact the existence of this diagnosis has on how mental health professionals think about gender nonconformity. Also, a study on social workers specifically might help to better understand specific social work education reform that is needed. Such a study could expand on social worker knowledge about the gender nonconformity that may be lacking. It could seek to understand how effective mental health professionals currently practice when working with gender nonconforming clients in order to understand what exactly needs to be addressed through education. It could aid in the development of a curriculum for social workers and other mental health professionals on this topic.

The impact that religion has on transphobia and the impact religion has on practicing in the mental health field and working with people of other religious/spiritual beliefs and experiences could also be studied. This would be helpful to understand how best to educate individuals of religious backgrounds on the gender nonconforming population in a way that would help to lower levels of transphobia.

Finally, further validation of the Genderism and Transphobia Scale adapted for mental health professionals is necessary. This study used convenience sampling, so the participants were not representative of the overall mental health professional population. In the future, the Genderism and Transphobia Scale adapted for mental health professionals should be tested for validation on a larger sample that is representative of the population.

References

- Cook, C., Heath, F., & Thompson, R. L. (January 01, 2000). A Meta-Analysis of Response Rates in Web- or Internet-Based Surveys. *Educational and Psychological Measurement*, 60, 6, 821-836.
- Diamond, L. M., & Savin-Williams, R. C. (2000). Explaining Diversity in the Development of Same-Sex Sexuality Among Young Women. *Journal of Social Issues*, 56 (2).
- Ehrbar, R. D., Witty, M. C., Ehrbar, H. G., & Bockting, W. O. (2008). Clinician judgment in the diagnosis of gender identity disorder in children. *Journal of Sex & Marital Therapy*, 34 (5), 385-412.
- Erich, S., Tittsworth, J., & Kersten, A. S. (2010). An examination and comparison of transsexuals of color and their white counterparts regarding personal well-being and support networks. *Journal Of GLBT Family Studies*, 6 (1).
- Factor, R. J., & Rothblum, E. D. (2007). A study of transgender adults and their non-transgender siblings on demographic characteristics, social support, and experiences of violence. *Journal Of LGBT Health Research*, 3 (3), 11-30.
- Hill, D., & Willoughby, B. (2005). The Development and Validation of the Genderism and Transphobia Scale. *Sex Roles*, 53, 7-8.
- Hyde, J.S., & Durik, A.M. (2000). Gender differences in erotic plasticity-evolutionary or sociocultural forces? Comment on Baumeister (2000). *Psychological Bulletin*, 126 (3), 375-379.
- Lev A. I. (2005). Disordering Gender Identity: Gender Identity Disorder in the DSM-IV-TR. *Journal of Psychology & Human Sexuality*, 17, 35-69.
- Mallon, G. P. (1999). Knowledge for Practice with Transgendered Persons. *Journal of Gay &*

- Lesbian Social Services*, 10, 1-18.
- McPhail, B. (2004). Questioning Gender and Sexuality Binaries: What Queer Theorists, Transgendered Individuals, and Sex Researchers Can Teach Social Work. *Journal of Gay & Lesbian Social Services*, 17 (1), 3-21.
- Nemoto, T., Bödeker, B., & Iwamoto, M. (2011). Social support, exposure to violence and transphobia, and correlates of depression among male-to-female transgender women with a history of sex work. *American Journal Of Public Health*, 101 (10), 1980-1988.
- Rees-Turyn, A., Doyle, C., Holland, A., & Root, S. (2008). Sexism and Sexual Prejudice (Homophobia): The Impact of the Gender Belief System and Inversion Theory on Sexual Orientation Research and Attitudes toward Sexual Minorities. *Journal of LGBT Issues in Counseling*, 2 (1), 2-25.
- Saltzburg, S., & Davis, T. S. (, 2010). Co-authoring gender-queer youth identities: Discursive tellings and retellings. *Journal of Ethnic and Cultural Diversity in Social Work*, 19 (2), 87-108.
- Sennott, S. L. (January 01, 2011). Gender Disorder as Gender Oppression: A Transfeminist Approach to Rethinking the Pathologization of Gender Non-Conformity. *Women & Therapy*, 34, 93-113.
- Sennott, S., & Smith, T. (2011). Translating the sex and gender continuums in mental health: A transfeminist approach to client and clinician fears. *Journal of Gay and Lesbian Mental Health*, 15 (2), 218-234.
- Shipherd, J. C., Abramovitz, S., & Green, K. E. (2010). Transgender Clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay and Lesbian Mental Health*, 14, 2, 94-108.

- Spade, D., Utrecht, & Stryker, S. (2006). *Mutilating Gender*. New York, NY: Routledge.
- Warner, M. (1999). *The trouble with normal: Sex, politics, and the ethics of queer life*. New York: Free Press.
- Willoughby, B. L. B., Hill, D. B., Gonzalez, C. A., Lacorazza, A., Macapagal, R. A., Barton, M. E., & Doty, N. D. (2010). Who Hates Gender Outlaws? A Multisite and Multinational Evaluation of the Genderism and Transphobia Scale. *International Journal of Transgenderism*, 12 (4).
- Wylie, S. A., Corliss, H. L., Prokop, L. A., Prokop, L. A., & Austin, S. B. (2010). Socially Assigned Gender Nonconformity: A Brief Measure for Use in Surveillance and Investigation of Health Disparities. *Sex Roles*, 63, 3-4.

Appendix A

Part I

1. What is your professional title/credentials? _____
2. How old are you? _____
3. What religion, if any, do you identify with?
 - a. Christianity
 - b. Islam
 - c. Judaism
 - d. Buddhism
 - e. Hinduism
 - f. Sikhism
 - g. None
 - h. Other: _____
4. What is the sexual orientation that you most identify with?
 - a. Asexual
 - b. Bisexual
 - c. Gay
 - d. Heterosexual/Straight
 - e. Homosexual
 - f. Lesbian
 - g. Pansexual
 - h. Queer/Fluid
 - i. Questioning/Unsure
 - j. Two Spirit
 - k. Other: _____
5. What is your sex identity?
 - a. Female
 - b. Male
 - c. Female-to-Male Transsexual
 - d. Male-to-Female Transsexual
 - e. Intersex
6. What is your gender identity?
 - a. Man
 - b. Woman
 - c. Transgender - Male to Female

- d. Transgender - Female to Male
 - e. Genderqueer
 - f. Other: _____
7. Would you describe yourself as gender nonconforming?
 - a. Yes
 - b. No
 - c. Sometimes
 - d. I don't know
 - e. Prefer not to say
 8. Have you ever worked with a gender nonconforming client?
 - a. Yes
 - b. No
 - c. I don't know
 - d. Prefer not to say
 9. Do you feel that you are educated on the transgender population?
 - a. Yes
 - b. No
 - c. I don't know
 - d. Prefer not to say

Part II

6. Do you believe Gender Identity Disorder should be included in the DSM-V?
 6. Yes
 7. No
 8. I don't know
 9. Prefer not to say
7. If a gender nonconforming client used terminology that was unfamiliar to you to describe their gender identity, would you use that terminology to describe the person as well, even if you disagreed with it or it made you uncomfortable?
 1. Yes.
 2. No.
 3. I don't know
 4. Prefer not to say
8. Would you describe a gender nonconforming client as transgender even if without that self identification?
 2. Yes
 3. No
 4. I don't know
 5. Prefer not to say

9. Would you assume that a client had Gender Identity Disorder because they appeared to be gender nonconforming?
 3. Yes.
 4. No.
 5. I don't know
 6. Prefer not to say.
10. Would you ask what pronoun a gender nonconforming client preferred and then use that pronoun when referring to the person\ (He/She/Hir/They, etc.)?
 4. Yes
 5. No
 6. I don't know
 7. Prefer not to say
11. If you had a gender nonconforming client, would you ask how the person identified (Man, Woman, Trans, Queer, etc.)?
 5. Yes
 6. No
 7. I don't know
 8. Prefer not to say
12. Do you believe there are only two genders?
 5. Yes
 6. No
 7. I don't know
 8. Prefer not to say
13. Do you have a good understanding of the difference between sex and gender?
 6. Yes
 7. No
 8. I don't know
 9. Prefer not to say

Part III

Please choose the answer that is most correct for you. 1 means strongly agree, and 5 means strongly disagree.

7. If I had an effeminate male client, I would feel anger towards him for not conforming to his gender.

1	2	3	4	5
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8. If I had a masculine female client, I would feel anger towards her for not conforming to her gender.

1 2 3 4 5

9. If I found out that my client was changing his or her sex, I would try to talk him or her out of it.

1 2 3 4 5

10. God made two sexes and two sexes only.

1 2 3 4 5

11. If a client wanted to have his penis removed and live as a woman in order to feel more comfortable, I would support him in doing so.

1 2 3 4 5

12. I have teased a man because of his feminine appearance or behavior.

1 2 3 4 5

13. Men who cross-dress for sexual pleasure disgust me.

1 2 3 4 5

14. Children should be encouraged to explore their masculinity and femininity.

1 2 3 4 5

15. If a client presented as a man, but I thought he was really a woman, I would ask him if he was a man or a woman.

1 2 3 4 5

16. Men who act like women should be ashamed of themselves.

1 2 3 4 5

17. Men who shave their legs are weird.

1 2 3 4 5

18. I cannot understand why a woman would act masculine.

1 2 3 4 5

19. I have teased a woman because of her masculine appearance or behavior.

1 2 3 4 5

20. Children should play with toys appropriate to their own sex.

1 2 3 4 5

21. Women who see themselves as any gender outside of “women” are abnormal.

1 2 3 4 5

22. I would have trouble talking with a client if I knew they had a surgically created penis and testicles.

1 2 3 4 5

23. A man who dresses as a woman is a pervert.

1 2 3 4 5

24. A male client has admitted to me that he got violent toward a woman he was dating when he found out that she had a penis. I understand where he is coming from because I would have gotten violent in that situation, too.

1 2 3 4 5

25. Feminine boys should be cured of their problem.

1 2 3 4 5

26. I have behaved violently toward a man because he was too feminine.

1 2 3 4 5

27. Passive men are weak.

1 2 3 4 5

28. If a man wearing makeup and a dress, who also spoke in a high voice, approached my child, I would use physical force to stop him.

1 2 3 4 5

29. Individuals should be allowed to express their gender freely.

1 2 3 4 5

30. It is morally wrong to not conform to your gender.

1 2 3 4 5

31. Feminine men make me feel uncomfortable.

1 2 3 4 5

32. I would go to a bar that was frequented by females who used to be males.

1 2 3 4 5

33. People are either men or women.

1 2 3 4 5

34. I would or have made jokes to colleagues or friends about a male client that dresses like a woman.

1 2 3 4 5

35. Masculine women make me feel uncomfortable.

1 2 3 4 5

36. It is morally wrong for a woman to present herself as a man in public.

1 2 3 4 5

37. It is all right to make fun of people who cross-dress.

1 2 3 4 5

38. If I encountered a male who wore high-heeled shoes, stockings, and makeup, I would consider harming him.

1 2 3 4 5

If you have any additional comments, please use the following space to share them:

Appendix B

Script of Explanation of Research for Clinical Directors' Meeting

“My name is Julie Cochran, and I’m an undergraduate social work student at Ohio State University. I am currently in the process of completing an honors thesis on the relationship between the way in which mental health professionals conceptualize gender nonconformity and any transphobic beliefs that they may have. I am planning to give a questionnaire to mental health professionals in Columbus. I am hoping that I can provide each of you with questionnaires to pass out to the employees of your respective agencies. Participating in this research could help provide some insight on how the employees at your agency think about gender nonconformity, and I would be happy to share my findings with you. Those that complete the questionnaire will be entered into a raffle to win one of seven \$50 gas cards. I appreciate your consideration in helping me complete this research. If you have any questions, please feel free to ask me or my thesis advisor, Dr. Tamara Davis. Thank you very much.”

Appendix C

Consent Information

The Ohio State University Consent to Participate in Research

Study Title: Conceptualization of Gender Nonconformity Among Mental Health Professionals

Researcher: Julie Cochran

Sponsor: College of Social Work, The Ohio State University

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate.

Your participation is voluntary.

Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. If you decide to participate, you will be asked to sign this form and will receive a copy of the form.

Purpose: The purpose of this study is to gain information about how mental health professionals conceptualize and understand gender nonconformity. This study is also interested in how mental health professionals differ in their conceptualizations of gender nonconformity across disciplines. This study seeks to identify whether there is a need for further related education of mental health professionals and those studying to be a mental health professional.

Procedures/Tasks: Attached is a questionnaire that you may choose to complete. You can either complete the paper copy of the questionnaire, or go to the website listed on it and complete it online. By completing the questionnaire, you are providing consent for participation. Your answers will remain anonymous. If you choose to complete the paper copy of the questionnaire, you can put it in the stamped/addressed envelope provided and drop it in a mailbox when you are finished with it. After completing the questionnaire, you may tear off the last sheet of this questionnaire and go to the website provided to enter your email address to be entered into a raffle to win one of seven \$50 gas cards. For those that complete the online questionnaire, you will be given the link to the website to enter your email at the end of the questionnaire. Entering your email on this website will not connect your name to the answers on your completed questionnaire in any way. The questionnaires will be destroyed three years after the completion of this research.

Duration:

You may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with The Ohio State University.

Risks and Benefits:

There are minimal risks to participating in this study. There is potential for experiencing negative emotions due to the content of the questionnaire. There is no direct benefit to completing the questionnaire, but this research may identify a need for further research and education on this topic.

Confidentiality:

Efforts will be made to keep your study-related information confidential. No personally identifiable information will be gathered and none of your responses will be connected to you in any way. However, there may be circumstances where information gathered through this study must be released. For example, personal information regarding your participation in this study may be disclosed if required by state law. Also, your records may be reviewed by the following groups (as applicable to the research):

10. Office for Human Research Protections or other federal, state, or international regulatory agencies;
11. The Ohio State University Institutional Review Board or Office of Responsible Research Practices;
12. The sponsor supporting the study.

Incentives:

After participating in this study, you will have the option of entering your email address on an online questionnaire (separate from the online research questionnaire). Seven participants will be randomly selected from this list to win a \$50 gas card.

Participant Rights:

You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled. If you are a student or employee at Ohio State, your decision will not affect your grades or employment status.

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

An Institutional Review Board responsible for human subjects research at The Ohio State University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

Contacts and Questions:

For questions, concerns, or complaints about the study you may contact my thesis advisor, Dr. Tamara Davis at Davis.2304@osu.edu or me at Cochran.299@osu.edu.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

If you are harmed as a result of participating in this study or for questions about a study-related injury, you may contact Dr. Davis or myself at the emails listed above.

By completing the following questionnaire (on paper or online), you are providing informed consent to participate in this study. You may keep this copy of the consent or print it if completing the questionnaire online.

Appendix D

Recruitment Letter

To Potential Research Participants:

My name is Julie Cochran, and I am a senior social work major at Ohio State. I am currently in the process of completing an honors thesis. My thesis is exploring the ways that mental health professionals conceptualize gender nonconformity. I have selected several agencies throughout Columbus to recruit participants for my study, and this agency is one that has been selected based on the fact that it serves individuals of all ages, it offers mental health treatment for a wide range of issues, and it employs social workers to provide services.

Attached to this letter is a questionnaire that will take you 10-15 minutes to complete. You have the option of completing the questionnaire on the paper copy provided or completing it online by going to the website below. If you choose to complete the paper questionnaire, please put it in the envelope provided and place it in a mailbox after you have completed it. Your answers will remain anonymous, and no identifying information will be asked of you in the questionnaire. Your participation is completely voluntary, and more information about your consent in participating in this research can be found on the next page. If you do participate, you will be offered an opportunity to be entered into a raffle to win one of seven \$50 gas cards. To enter the raffle, tear off the small paper and enter your email address. Emails will be randomly drawn, and winners will be notified when data collection is complete. Your email will not be connected to the answers you provide on your questionnaire.

I really appreciate your participation in helping me complete my thesis. I will provide a summary of my findings to your agency in the spring. Thank you very much!

Sincerely,

Julie Cochran